ARC 3481C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed Emergency

Pursuant to the authority of Iowa Code section 249A.4 and 2017 Iowa Acts, House File 653, section 93, the Department hereby amends Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," and Chapter 83, "Medicaid Waiver Services," Iowa Administrative Code.

These amendments will change the rate-setting methodology used to develop supported community living (SCL), day habilitation, and adult day care service rates in the home- and community-based services (HCBS) intellectual disability waiver. The SCL methodology will change from the current retrospectively limited prospective rate-setting process to a fee schedule using a tiered-rate methodology. Day habilitation and adult day care service rates are currently established through a fee schedule but will be changed to a fee schedule using tiered rates. The tiered-rate methodology establishes a tiered system of reimbursement based on the identified acuity level from the results of the Supports Intensity Scale® (SIS) core standardized assessment.

The move to tiered rates will be cost-neutral to the Department. The tiered-rate funding methodology will assign a standardized service rate based on member need unlike the current methodology of services reimbursement based on provider costs. With this change, some providers will see increased revenues compared to current service reimbursement for the members currently served and other providers will see decreased revenues.

The Council on Human Services adopted these amendments on November 8, 2017.

Pursuant to Iowa Code section 17A.4(3), the Department finds that notice and public participation are unnecessary because emergency rule making is authorized by 2017 Iowa Acts, House File 653, section 93.

Pursuant to Iowa Code section 17A.5(2)"b"(1)(a), the Department also finds that the normal effective date of these amendments, 35 days after publication, should be waived and the amendments made effective December 1, 2017, because 2017 Iowa Acts, House File 653, section 93, authorizes the Department to adopt emergency rules.

These amendments are also published herein under Notice of Intended Action as **ARC 3476C** to allow for public comment.

These amendments do not provide for waivers in specified situations because requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 249A.4 and 2017 Iowa Acts, House File 653, section 93.

These amendments became effective December 1, 2017.

The following amendments are adopted.

ITEM 1. Amend paragraph **78.41(1)"f,"** introductory paragraph, as follows:

f. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, ~~the total costs shall not exceed $1570 per member per year,~~ and the provider must maintain records to support the expenditures. A unit of service is:

ITEM 2. Amend subrule 78.41(11) as follows:

78.41(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed ~~simultaneously with~~ when HCBS intellectual disability waiver daily supported

community living service ~~when the transportation costs are included within the supported community living reimbursement rate~~ is authorized in a member's service plan.

ITEM 3. Amend paragraph **79.1(1)"c"** as follows:

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

(1) The actual charge made by the provider of service.

(2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: ~~http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html~~ dhs.iowa.gov/ime/providers/csrp/fee-schedule.

ITEM 4. Amend subrule 79.1(2), provider category "HCBS waiver service providers," paragraphs "1," "18," "25" and "26," as follows:

79.1(2) *Basis of reimbursement of specific provider categories.*

Provider category	Basis of reimbursement	Upper limit
1. Adult day care	For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Fee schedule	Effective 7/1/16, for AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/16 rate: Veterans Administration contract rate or $1.47 per 15-minute unit, $23.47 per half day, $46.72 per full day, or $70.06 per extended day if no Veterans Administration contract.
	For intellectual disability waiver: Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective ~~7/1/16~~ 7/1/17, for intellectual disability waiver: ~~County contract rate or, in the absence of a contract rate,~~ The provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute~~,~~ or half-day~~, full-day, or extended-day~~ rate. If no 6/30/16 rate, $1.96 per 15-minute unit~~,~~ or $31.27 per half day~~, $62.42 per full day, or $79.59 per extended day~~.

		For daily services, the fee schedule rate published on the department's website, pursuant to 79.1(1)*"c,"* for the member's acuity tier, determined pursuant to 79.1(30).
18. Supported community living	For brain injury waiver: Retrospectively limited prospective rates. See 79.1(15)	For ~~intellectual disability and~~ brain injury waiver effective 7/1/16: $9.28 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 3.927%.
	For intellectual disability waiver: Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	For intellectual disability waiver effective 7/1/17: $9.28 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1)*"c,"* for the member's acuity tier, determined pursuant to 79.1(30).
25. Residential-based supported community living	~~Retrospectively limited prospective rates. See 79.1(15)~~ Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective ~~7/1/16~~ 7/1/17: ~~Not to exceed the maximum ICF/ID rate per day plus 3.927%.~~ The fee schedule rate published on the department's website, pursuant to 79.1(1)*"c,"* for the member's acuity tier, determined pursuant to 79.1(30).
26. Day habilitation	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective ~~7/1/16~~ 7/1/17: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute ~~or daily~~ rate. If no 6/30/16 rate: $3.51 per 15-minute unit ~~or $68.23 per day~~. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1)*"c,"* for the member's acuity tier, determined pursuant to 79.1(30).

ITEM 5. Amend subrule 79.1(15) as follows:

79.1(15) *HCBS retrospectively limited prospective rates.* This methodology applies to reimbursement for HCBS brain injury waiver supported community living; HCBS family and community support services; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency.

a. No change.

b. Home- and community-based general rate criteria.

(1) to (4) No change.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed $1,570 per consumer per year for supported community living services in the brain injury waiver.

(6) to (9) No change.

c. to *g.* No change.

ITEM 6. Adopt the following **new** subrule 79.1(30):

79.1(30) *Tiered rates.* For supported community living services, residential-based supported community living services, day habilitation services, and adult day care services provided under the intellectual disabilities waiver, the fee schedule published by the department pursuant to paragraph 79.1(1)*"c"* provides rates based on the acuity tier of the member, as determined pursuant to this subrule.

a. Acuity tiers are based on the results of the Supports Intensity Scale® (SIS) core standardized assessment. The SIS assessment tool and scoring criteria are available on request from the Iowa Medicaid enterprise, bureau of long-term care.

b. The assignment of members to acuity tiers is based on a mathematically valid process that identifies meaningful differences in the support needs of the members based on the SIS scores.

c. For supported community living daily services paid through a per diem, there are two reimbursement sublevels within each tier based on the number of hours of day services a member receives monthly. Day services include enhanced job search services, supported employment, prevocational services, adult day care, day habilitation and employment outside of Medicaid reimbursable services. The two reimbursement sublevels reflect reimbursement for:

(1) Members who receive an average of 40 hours or more of day services per month.

(2) Members who receive an average of less than 40 hours of day services per month.

d. For this purpose, the "SIS activities score" is the sum total of scores on the following subsections:

(1) Subsection 2A: Home Living Activities;

(2) Subsection 2B: Community Living Activities;

(3) Subsection 2E: Health and Safety Activities; and

(4) Subsection 2F: Social Activities.

e. Also used in determining a member's acuity tier, as provided in paragraphs 79.1(30)*"f"* and *"g,"* are the subtotal scores on the following subsections:

(1) Subsection 1A: Exceptional Medical Support Needs, excluding questions 16 through 19; and

(2) Subsection 1B: Exceptional Behavioral Support Needs, excluding question 13.

f. Subject to adjustment pursuant to paragraph 79.1(30)*"g,"* acuity tiers are the highest applicable tier pursuant to the following:

(1) Tier 1: SIS activities score of 0 – 25.

(2) Tier 2: SIS activities score of 26 – 40.

(3) Tier 3: SIS activities score of 41 – 44 or SIS activities score of 0 – 40 and a SIS subsection 1B subtotal score of 6 or higher.

(4) Tier 4: SIS activities score of 45 or higher.

(5) Tier 5: SIS activities score of 41 or higher and a subsection 1B subtotal score of 7 or higher.

(6) Tier 6: SIS subsection 1A or 1B subtotal score of 14 or higher.

(7) RCF tier: Members residing in a residential care facility (RCF) licensed for six or more beds.

(8) RBSCL tier: Members residing in a residential-based supported community living (RBSCL) facility.

(9) Enhanced tier: An individual member rate negotiated between the department and the provider.

g. The tier determined pursuant to paragraph 79.1(30)*"f"* shall be adjusted as follows:

(1) For members with a subsection 1A subtotal score of 2 or 3, as provided in subparagraph 79.1(30)*"e"*(1), but with a response of "extensive support needed" (score = 2) in response to any prompt in subsection 1A, as provided in subparagraph 79.1(30)*"e"*(1) and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)*"f,"* the tier is increased by one tier.

(2) For members with a subsection 1A subtotal score of 4 – 9, and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)*"f,"* the tier is increased by one tier.

(3) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 1 to 3 pursuant to paragraph 79.1(30)*"f,"* the tier is increased by two tiers.

(4) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 4 pursuant to paragraph 79.1(30)*"f,"* the tier is increased by one tier.

(5) Any member may receive an enhanced tier rate when approved by the department for fee-for-service members.

h. Tier redetermination. A member's acuity tier may be changed in the following circumstances:

(1) There is a change in the member's SIS activity scores as determined in the annual level of care redetermination process pursuant to rule 441—83.64(249A).

(2) A completed DHS Form 470-5486, Emergency Needs Assessment, indicates a change in the member's support needs. A member's case manager may request an emergency needs assessment when a significant change in the member's needs is identified. When a completed emergency needs assessment indicates significant changes that are likely to continue in three of the five domains assessed, a full SIS core standardized assessment shall be conducted and any change in the SIS scores will be used to determine the member's acuity tier.

(3) A member's acuity tier assignment does not affect the services that the member will receive and is not considered an adverse action, and therefore there are no appeal rights.

i. New providers, provider acquisitions, mergers and change in ownership. Any change in provider enrollment status including, but not limited to, new providers, enrolled providers merging into one or more consolidated provider entities, acquisition or takeover of existing HCBS providers, or change in the majority ownership of a provider on or after December 1, 2017, shall require the new provider entity to use the tiered rate fee schedule in accordance with paragraph 79.1(1)*"c."*

ITEM 7. Adopt the following **new** paragraph **83.67(4)"i"**:

i. For members receiving daily supported community living, day habilitation or adult day care: the following scores from the most recently completed SIS assessment:

(1) Score on subsection 1A: Exceptional Medical Support Needs.

(2) Score on subsection 1B: Exceptional Behavioral Support Needs.

(3) Sum total of scores on the following subsections:

1. Subsection 2A: Home Living Activities;
2. Subsection 2B: Community Living Activities;
3. Subsection 2E: Health and Safety Activities; and
4. Subsection 2F: Social Activities.

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